Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WILLIAM K JACKSON

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-3082-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited and paid incorrectly … This rules states if a full physical evaluation, with range of motion, is performed, reimbursement for the first musculoskeletal body area is $300.00."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor argues he should be paid $300.00 for range of motion testing of the spine to arrive at the IR even though he documented the following … (See requestor's DWC-60 packet) But there is no explanation stating the need for the ROM and how it was used in an assistive way to calculate the IR."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 06, 2013	CPT Code 99456-WP-W5	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - CAC – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION

CALL 1-800-937-6824

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the total allowable amount for the impairment rating of the spine?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the lumbar spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that "The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area."

   The Division notes that the document titled *Medical Dispute Resolution Newsletter, No:4, March 2005* submitted by the requestor in support of its request is not applicable to the services in dispute. This article titled *Billing and Reimbursement for an Impairment Rating: ROM vs. DRE* discusses former §134.202, which is not applicable to the disputed service. The applicable rule is, as stated above, 28 Texas Administrative Code §134.204 adopted to be effective March 1, 2008, 33 TexReg 364.
2. According to the explanation of benefits and the respondent's position statement, the total of $150 was reimbursed by the carrier for the IR of the lumbar spine. The requestor disagrees, in its position, the requestor argues that the carrier should have allowed a total of $300 for the impairment rating of the lumbar spine because it asked for reimbursement based upon §134.204(j)(4)(C)(ii) **(II)(-a-) [emphasis added]**. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II)(-a-), the health care provider, in this case, was required to perform a full physical evaluation with range of motion of the lumbar spine. Review of the submitted documentation finds that the lumbar spine was rated using a full physical evaluation and range of motion. The Division concludes that the impairment rating of the lumbar spine is allowed at $300 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-a-).
3. The division concludes that the total allowable for the impairment rating of the lumbar spine is $300. The respondent issued payment in the amount of $150 for the IR of the spine. Based upon the documentation submitted, additional reimbursement in the amount of $150 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/11/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.